Michigan State University
Occupational Health
East Lansing, MI 48824-1037
(517) 353-9137

INITIAL MEDICAL QUESTIONNAIRE FOR INDIVIDUAL WHO WEARS A RESPIRATOR

INSTRUCTIONS: Please answer all questions honestly and completely. Questions are for record keeping purposes and to check for heart or lung disease that may place you at risk of becoming ill when you wear a respirator. Information will be kept confidential and will be reviewed by professional medical personnel only. If you wish to talk to the Health Care Professional who will be reviewing this questionnaire, please call MSU Occupational Health at (517) 353-9137.

Name: _____ Last _____ First _____ Middle	
Address: _____ Street _____ City _____ State _____ Zip	
Home Phone: ( )	
ZPID or APID:	Date of Birth:
Department:	Job Title:
Phone number we can reach you at work:	Supervisor:
Height: (without shoes)	
Weight: (without shoes)	

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1.	Have you ever smoked cigarettes?		
	IF "YES," ANSWER QUESTIONS 1a-1e. IF "NO", SKIP TO QUESTION 2	Yes ☐	No ☐
a.	Do you smoke now?	Yes ☐	No ☐
b.	How old were you when you started smoking regularly?		
c.	If you stopped, how old were you when you stopped?		
d.	On the average, how many packs per day have you smoked for the length of time you smoked?		
e.	How many packs per day do you smoke now?		

2.	Have you ever had any of the following conditions?		
a.	Seizures:	Yes ☐	No ☐
b.	Diabetes (sugar disease):	Yes ☐	No ☐
c.	Allergic reactions that interfere with your breathing:	Yes ☐	No ☐
d.	Claustrophobia (fear of closed-in places):	Yes ☐	No ☐
e.	Trouble smelling odors	Yes ☐	No ☐

3.	Have you *ever had* any of the following pulmonary or lung problems?		
a.	Asbestosis:	Yes ☐	No ☐
b.	Asthma:	Yes ☐	No ☐
c.	Chronic bronchitis:	Yes ☐	No ☐
d.	Emphysema:	Yes ☐	No ☐
e.	Pneumonia:	Yes ☐	No ☐
f.	Tuberculosis:	Yes ☐	No ☐
g.	Silicosis:	Yes ☐	No ☐
h.	Pneumothorax (collapsed lung):	Yes ☐	No ☐
i.	Lung cancer:	Yes ☐	No ☐
j.	Broken ribs:	Yes ☐	No ☐
k.	Any chest injuries or surgeries:	Yes ☐	No ☐
l.	Any other lung problem that you've been told about:	Yes ☐	No ☐

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4.	Do you *currently* have any of the following symptoms of pulmonary or lung illness?		
a.	Shortness of breath:	Yes ☐	No ☐
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes ☐	No ☐
c.	Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes ☐	No ☐
d.	Have to stop for breath when walking at your own pace on level ground:	Yes ☐	No ☐
e.	Shortness of breath when washing or dressing yourself:	Yes ☐	No ☐
f.	Shortness of breath that interferes with your job:	Yes ☐	No ☐
g.	Coughing that produces phlegm (thick sputum):	Yes ☐	No ☐
h.	Coughing that wakes you early in the morning:	Yes ☐	No ☐
i.	Coughing that occurs mostly when you are lying down:	Yes ☐	No ☐
j.	Coughing up blood in the last month:	Yes ☐	No ☐
k.	Wheezing:	Yes ☐	No ☐
l.	Wheezing that interferes with your job:	Yes ☐	No ☐
m.	Chest pain when you breathe deeply:	Yes ☐	No ☐
n.	Any other symptoms that you think may be related to lung problems:	Yes ☐	No ☐

5.	Have you *ever had* any of the following cardiovascular or heart problems?		
a.	Heart attack:	Yes ☐	No ☐
b.	Stroke:	Yes ☐	No ☐
c.	Angina:	Yes ☐	No ☐
d.	Heart failure:	Yes ☐	No ☐
e.	Swelling in your legs or feet (not caused by walking):	Yes ☐	No ☐
f.	Heart arrhythmia (heart beating irregularly):	Yes ☐	No ☐
g.	High blood pressure:	Yes ☐	No ☐
h.	Any other heart problem that you've been told about:	Yes ☐	No ☐

6.	Have you *ever had* any of the following cardiovascular or heart symptoms?		
a.	Frequent pain or tightness in your chest:	Yes ☐	No ☐
b.	Pain or tightness in your chest during physical activity:	Yes ☐	No ☐
c.	Pain or tightness in your chest that interferes with your job:	Yes ☐	No ☐
d.	In the past two years, have you noticed your heart skipping or missing a beat:	Yes ☐	No ☐
e.	Heartburn or indigestion that is not related to eating:	Yes ☐	No ☐
f.	Any other symptoms that you think may be related to heart or circulation problems:	Yes ☐	No ☐

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7.	Do you *currently* take medication for any of the following problems?		
a.	Breathing or lung problems:	Yes ☐	No ☐
b.	Heart trouble:	Yes ☐	No ☐
c.	Blood pressure:	Yes ☐	No ☐
d.	Seizures:	Yes ☐	No ☐

8.	What is your most recent blood pressure? **(Required)** _____/_____ **Must provide a blood pressure reading done within the past year. If you have not had a blood pressure taken in the last year, you may call Occupational Health (353-9137) to schedule a time to get your blood pressure taken and you may return your questionnaire at that time.**		
9.	Have you had any treatment for high blood pressure (hypertension) in the past ten years?	Yes ☐	No ☐
	If "YES", PLEASE LIST WHAT MEDICATION(s) YOU TAKE FOR YOUR HIGH BLOOD PRESSURE: _____ _____ _____ _____ _____ _____ _____		

10.	Which type of respirator (a mask that protects you against exposure to dusts or chemical fumes) will you use?		
a.	N, R, or P disposable respirator (filter-mask, non-cartridge type only)	Yes ☐	No ☐
b.	Other types (For example, half or full-face piece, powered-air purifying, supplied-air self-contained breathing apparatus (SCBA)	Yes ☐	No ☐
c.	How often do you expect to wear a respirator? (For example: 3 times per week, 10 times per month)		
d.	How long do you expect to typically wear your respirator without taking it off? (For example: 15 min., 30 min., 1 hour, 4 hours)		
e.	What duties will you perform while using the respirator? (For example: patient care, painting, applying pesticides, cleaning, asbestos removal, etc.)		
f.	Briefly describe your working environment when you will be wearing your respirator. (For example: patient area, research lab, farm area, steam tunnel, penthouse, etc.)		

11.	Have you *ever* had any of the following problems when you wore a respirator?		
a.	Eye irritation:	Yes ☐	No ☐
b.	Skin allergies or rashes:	Yes ☐	No ☐
c.	Anxiety:	Yes ☐	No ☐
d.	General weakness or fatigue:	Yes ☐	No ☐
e.	Any other problem that interferes with your use of a respirator:	Yes ☐	No ☐

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12.	Have you ever had a breathing test? (For example: Spirometry or Pulmonary Function Test)?	Yes ☐	No ☐
	If "YES", WHAT WERE THE RESULTS? Normal ☐ Abnormal ☐ Don't Know ☐		

13.	Have you ever had an electrocardiogram (ECG or EKG)?	Yes ☐	No ☐
	If "YES", WHAT WERE THE RESULTS? Normal ☐ Abnormal ☐ Don't Know ☐		

14.	Do you have a beard?	Yes ☐	No ☐
	If "YES", WOULD YOU SHAVE YOUR BEARD IF YOU WERE REQUIRED TO FOR A JOB? _____		

15.	Do you consider yourself in good health?	Yes ☐	No ☐
	If "NO", STATE REASONS? _____		

16.	When was your last general medical examination? _____

17.	List all medications you take on a regular basis (include those you can buy without a prescription). If you don't know the name, list what the pill is for (For example: heart pill or water pill). _____ for _____ _____ for _____ _____ for _____ _____ for _____ _____ for _____ _____ for _____ _____ for _____ _____ for _____ _____ for _____ _____ for _____

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Questions 18 to 23 below must be answered ***ONLY* by employees who will be required to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). IF YOU WILL NOT BE USING A FULL-FACED RESPIRATOR OR SCBA, SKIP TO QUESTION 24.**			
18.	Have you *ever lost* vision in either eye (temporarily or permanently)?	Yes ☐	No ☐
19.	Do you *currently* have any of the following vision problems?		
a.	Wear contact lenses:	Yes ☐	No ☐
b.	. Wear glasses:	Yes ☐	No ☐
c.	Color blind:	Yes ☐	No ☐
d.	Any other eye or vision problem:	Yes ☐	No ☐
20.	Have you *ever had* an injury to your ears, including a broken ear drum?	Yes ☐	No ☐
21.	Do you *currently* have any of the following hearing problems?		
a.	Difficulty hearing:	Yes ☐	No ☐
b.	Wear a hearing aid:	Yes ☐	No ☐
c.	Any other hearing or ear problem:	Yes ☐	No ☐
22.	Have you *ever had* a back injury?	Yes ☐	No ☐
23.	Do you *currently* have any of the following musculoskeletal problems?		
a.	Weakness in any of your arms, hands, legs, or feet:	Yes ☐	No ☐
b.	Back pain:	Yes ☐	No ☐
c.	Difficulty fully moving your arms and legs:	Yes ☐	No ☐
d.	Pain or stiffness when you lean forward or backward at the waist:	Yes ☐	No ☐
e.	Difficulty fully moving your head up or down:	Yes ☐	No ☐
f.	Difficulty fully moving your head side to side:	Yes ☐	No ☐
g.	Difficulty bending at your knees:	Yes ☐	No ☐
h.	Difficulty squatting to the ground:	Yes ☐	No ☐
i.	Climbing a flight of stairs or a ladder carrying more than 25 lbs.:	Yes ☐	No ☐
j.	Any other muscle or skeletal problem that interferes with using a respirator:	Yes ☐	No ☐

24.	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	Yes ☐	No ☐

You are done! Please mail, email or fax this completed questionnaire to: MSU Occupational Health, 463 E. Circle Drive, Room 123, East Lansing, MI 48824 (located in Olin Health Center). Fax: (517) 355-0332 or Email: HT.occhealth@msu.edu